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ABSTRACT

This package is one of a series of repackaged products aimed at alerting UNESCO users to a wealth of highly valuable educational resources that exist in the field of adolescent reproductive and sexual health. This document focuses on what research says is the impact of peer education in promoting necessary changes among adolescents in attitudes and behavior with regard to reproductive and sexual health. There is an increasing effort in countries in the region and elsewhere to employ a peer approach in their adolescent programs and activities to facilitate delivery of the message and acceptance. From these initiatives, experiences in the use of the peer approach have grown which has in turn generated a number of materials that document key strategies and lessons learned. This book synthesizes these experiences and shares lessons learned as well as offering guidelines to enable policymakers and program implementers to learn from others and possibly adopt/adapt those strategies that will have the greatest potential to succeed in their own setting. (Author/SOE)

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Peer Approach in Adolescent Reproductive Health Education: Some Lessons Learned

SE 068 253

United Nations Educational, Scientific and Cultural Organization
UNESCO Bangkok

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UNESCO Regional Clearing House
on Population Education and Communication
Asia and Pacific Regional Bureau for Education
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UNFPA Adolescent Reproductive Health Project (MON/02/P06), Mongolia -- Page 2

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List of Abbreviations

ARH	Adolescent reproductive health
ART	Red Crescent AIDS Task Force
AIDS	Acquired immune deficiency syndrome
CAPS	Centre for AIDS Prevention Studies
CFPA	China Family Planning Association
CRUSH	Community Resources for Under 18s on STDs and HIV
CSWs	Commercial sex workers
FLE	Family life education
FP	Family planning
FPAI	Family Planning Association of India
ICPD	International Conference on Population and Development
PLWA	People living with AIDS
RHAC	Reproductive Health Association of Cambodia
SEATS	Family Planning Service Expansion and Technical Support (a project)
SCERT	Sex Education, Counseling, Research, Training and Therapy
SH	Sexual health
S/RH	Sexual/Reproductive health
SMASH	Social Marketing for Adolescent Sexual Health
STD/HIV	Sexually transmitted diseases/Human immunodeficiency virus
STI	Sexually transmitted infection
TAMPEP	Transnational AIDS/STD Prevention among Migrant Prostitutes Project
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Preface

This package is one of a series of repackaged products aimed at alerting our users to a wealth of highly valuable educational resources that exist in the field of adolescent reproductive and sexual health, but would have never been read simply because they are not easily accessible. Even if they can be accessed, they are often scattered in many storehouses and require time to synthesise. In addition, they are written in either highly technical or unreadable language.

The strategy of the UNESCO Regional Clearing House to consolidate and repackage information addresses this potential waste of resources by reviewing, analysing and selecting the most useful and relevant information, screening out poor resources processing products into more readable language, culling out policy and practice implications, and repackaging into attractive formats that are readable and applicable to decision-making and programme improvements. To implement this strategy, the Regional Clearing House is releasing a series of packages, which focus on different topics or areas of importance to adolescents, for the use of teachers, trainers, curriculum developers, school administrators and policy-makers.

This package is on peer education

Objective

This document focuses on what research says is the impact of peer education in promoting the necessary changes among adolescents in attitudes and behaviour with regard to reproductive and sexual health. There is an increasing effort in countries in the region and elsewhere to employ a peer approach in their adolescent programmes and activities to facilitate delivery of the message and acceptance. From these initiatives, experiences in the use of peer approach have grown which has in turn generated a number of materials that document key strategies and lessons learned. This particular booklet synthesises these experiences and shares lessons learned, as well as offering guidelines to enable policy makers and programme implementers to learn from others and possibly to adopt/adapt those strategies that will have the great at potential to succeed in their own setting.

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Contents of the booklet

Chapter One: What is Peer Education? – defines what peer education is; how it came about and became recognised as an effective strategy for reaching youth with reproductive and sexual health messages; it explains the theoretical models in which the peer approach is grounded; and describes the characteristics and requirements of peer education and the role of a peer educator.

Chapter Two: Why Use Peer Education? – justifies using peer education in changing attitudes and behaviour by showing the advantages and benefits of peer education.

Chapter Three: What Research Says About the Peer Approach – synthesises findings from research assessing the influence and impact of peer education on teen pregnancy prevention, STD/HIV/AIDS prevention, overall knowledge of reproductive and sexual health, and its influence on peer educators, culling from experiences in Cambodia, China, India and other countries from other continents.

Chapter Four: Lessons Learned – compiles the lessons learned from many research studies, showing what makes a peer education programme work and how to ensure success when working with teens.

Chapter Five: Guidelines – presents a series of guidelines to address different aspects of adolescent reproductive health intervention planning and implementation from project formulation and planning to implementing activities, to selecting and training peer educators. It also includes tips for working with youth, working with adults, and sample lesson plans from a peer educator's training manual.

Source of materials

The information in this booklet is based on research studies, synthesis of research, reports and manuals generated not only in Asia and the Pacific, but also in Africa and Latin America. Moreover, the booklet documents experiences on the use of peer education accumulated over the years. We hope that countries which also have successfully used peer education in reproductive and sexual health will inform us so we can update our information resources in this area. Please send your experiences, best

practices and lessons learned on peer education in adolescent reproductive and sexual health to rechpec@unescobkk.org. Visit our website: http://www.unescobkk.org/ips/arh-web and fill in the contribution form.

What is Peer Education?

CHAPTER ONE

The beginning of adolescence is a formative period in everyone's social development. It is a time when choosing friends and belonging to various groups takes on new importance. Most often, as the adolescent develops, peer groups slowly supercede family as a young person's primary social outlet. Peer groups aid young individuals in gaining a sense of their own identity by providing a social identity usually for the first time in a young person's life. That is, by way of association with others, young people gain a firmer sense of who they are. This, in turn, leads to the development and practice of social skills that will stay with them throughout their lives. *Peer education* seeks to utilise the positive aspects of adolescent peer groups by helping them learn from each other – something they do naturally anyway.

A peer is a person who "is of equal standing with another; one belonging to the same societal group, especially based on age, grade or status" (Population Council, June 2003, p. 2). An adolescent peer group is usually defined not only by age, but also

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by shared interests, such as participation in sports, non-participation in sports, school activities and other clubs, or other shared social characteristics. For the purpose of *peer education*, it does not matter how or why any group is formed, it is only important to identify the group and select an individual who will act as a 'peer educator' for that group. A "peer educator" is someone who belongs to such a group as an equal participating member, but who receives special training and information so that this person may bring about or sustain positive behaviour change among group members.

Peer education, in its broadest sense, refers to a programme designed to train select members of any group of equals, (school, office, factory, etc.), to effect change among members of that same group. For the purpose of this package, that understanding holds true. But additional focus will be placed on peer education as a carefully planned and implemented strategy to train representative adolescents, providing them with information on issues relating to adolescent reproductive health. Hopefully, this will allow them to share information with their immediate peer group and others.

There are two main avenues that peer-based intervention programmes tend to pursue. One is the 'peer support model'. This includes groups that reinforce behaviour change for those in, for example, recovery from alcohol or other chemical addiction. Peer support groups might also be appropriate for helping members through a traumatic experience, such as sexual abuse, death of a loved one, or a serious illness. In these groups, all members act as equals in the group *(RECAPP, "Peer Education" http://www.etr.org/recapp/column/column200205.htm).*

The other main branch of peer-based interventions, and the area that this package will focus on, is the "peer leadership model". This is when one member of a group is singled out for special training and education so that this person may better facilitate a desired change within the group. The peer educator may be trained to assist adult educators/trainers, or to facilitate the groups themselves.

It is important to understand that peer education programmes require careful planning, the identification and training of peer educators, and follow-up

evaluations. Simply getting a group of adolescents together to discuss a serious topic is not an application of peer education.

Lastly, peer education is but one of many avenues of communication and information dissemination that can and should be applied to issues related to adolescent reproductive health. It is one tool, generally considered to be a very effective in the arsenal of teachers and health authorities charged with combating the threat posed to the lives and well being of youth by HIV/AIDS and other STDs. However, this package does not intend to promote peer education as the only, or necessarily the best, approach.

Background

Though not entirely new at the time, recognition of the effectiveness of peer support groups took shape with the founding of Alcoholic's Anonymous in 1935. This gave birth to a plethora of 12-Step programmes which are all exemplary models of the peer support group. Participants share a common characteristic, or problem, which brings them together, they interact as untrained co-equals, and they help reinforce the desired behaviour change.

The peer leadership model has been applied to changing adolescent behaviour, especially in regards to pregnancy prevention, for thirty or forty years. It has been applied to many health-related issues, including nutrition education, family planning, substance abuse, and violence prevention. Perhaps the model's greatest advantage is that it first recruits youth peer educators to help define and establish standards of acceptable behaviour within their own community. Because youth, themselves, play an important part in formulating standards, they go on to serve as effective positive role models within their groups. As such, peer educators are usually well received within their communities as credible disseminators of information and advice.

Theoretical Models

In general, peer education is based on "behavioural theory which asserts that people make changes not because of scientific evidence or testimony but because of subjective judgement of close, trusted peers who have adopted changes and who act as persuasive role models for change" (Peer education UNAIDS, 1999, p. 10). Peer education finds its basis in the following social theories:

Social Learning Theory asserts that people serve as role models for others and that some people are capable of directly eliciting behavioural change in certain individuals (Bandura, 1986, p. 6).

The *Theory of Reasoned Actions* states that one of the influential elements for change of behaviour is an individual's perception of social norms, or beliefs, about what people who are important to the individual do or think about a particular behaviour (Fishbein & Ajzen, 1975, p. 6).

The *Diffusion of Innovation Theory* suggests that certain individuals (opinion leaders) from a given population act as change agents within that population (Rogers, 1983, p. 6).

The *Theory of Participatory Education* has also been important in the development of peer education (Freire, 1970). "Participatory or empowerment models of education posit that powerlessness at the community or group level, and the economic and social conditions inherent to the lack of power are major risk factors for poor health" (Amaro, 1995, p. 6) (UNAIDS, 1999, p. 6).

Characteristics and requirements of Peer Education

For peer education to be effective, careful identification and training of the peer educators is essential. Peer educators should possess good communication skills that will be enhanced through training. They must be able to see and understand the issues at hand through the perspectives

of the members of the group. Peer educators are usually well placed within the target group, not on the fringes; however, they need not necessarily already be a group leader. Sometimes effective peer educators are those who have a strong commitment about the work and actively pursue ways to get involved. Others are identified, by teachers or programme supervisors, and recruited to participate in the programme.

It is generally assumed that peer education is one of the least expensive strategies to employ to effectively reach a target population. However, the recruitment and training of peer educators takes time. It also takes time to monitor and supervise them once the training period is over. Moreover, a good peer education programme should build in a regimen of continuous training for peer educators to help remind them about what they are trying to accomplish, while enhancing their skills to aid them on the way.

Furthermore, peer education programmes typically experience a high turnover rate of peer educators, so it is usually necessary for the recruitment and initial training phases be undertaken continuously.

Lastly, there seems to be a growing consensus that peer educators should be compensated in some way for their time and efforts. However, this can prove problematic because, while it might reduce the turnover rate among peer educators and while it appeals to a sense of fairness, it might also create a kind of barrier between them and their groups. In other words, they may no longer be accepted as genuine co-equals within the group.

Suggested Job Responsibilities for a Peer Educator

Once trained, a peer educator might perform any of the following activities. This depends on the overall plan of the programme. The activities include:

- Conduct workshops on issues related to Adolescent Reproductive Health;
- Facilitate small group meetings;
- Disseminate information – and act as a resource of good information for the group and/or larger target community;
- Organise or set up information displays that might, for example, include distributing condoms;
- Provide counseling and advice on a one-to-one basis;
- Make referrals for professional help for individuals in special need;
- Help recruit other peer educators; and
- Help continue to modify the programme to better serve the target community.

An Early Example from Lucknow, India

In 1978, the Family Planning Association of India (FPAI) initiated an innovative approach to "dispel the confusions and misconceptions surrounding human sexuality, marriage and contraception" (Chakraborty, n.d., p. 1 of 12). The FPAI started the Sex Education, Counseling, Research, Training and Therapy (SCERT) programme that set up centres offering counseling along with family planning services. Although its first target population was married couples, the programme gave particular emphasis to youth.

Then, in Lucknow, the local FPAI centre started a youth programme by organising a workshop to disseminate reproductive health information and identify potential peer counselors. Such an impression was made during the workshop that a number of youth participants expressed their interest in forming a club. Two more workshops ensued and finally 25 peer educators were identified for special training. Besides provision of information on all issues relating to reproductive health, especially as it pertains to young people, the peer educators were trained in the following skills (ibid. p. 2 of 12):

- Counseling;
- Communication;
- Leadership and management;
- Resource finding and mobilisation; and
- Use of audio visual aids.

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Calling themselves the "Young Inspirers", the peer educators realised that for their efforts to be successful, they would have to get their peers actively involved. They organised many special activities, such as exhibitions, poster, role-play and debate competitions, stage dramas and musical productions to get their message across to their target audience. They also provided and led more traditional lectures, and performed counseling duties at the centre. Their activities always focused on one or two issues considered most relevant for a given age group. For instance, health and hygiene information would be considered more appropriate for a younger crowd, while information on HIV/AIDS and contraception would be appropriate for older youth.

Feedback on the efforts of the Young Inspirers was instantly very positive, with young people acknowledging that they preferred to receive ARH information from their trained peers. At the same time, teachers, many of whom admitted that they were uncomfortable teaching ARH themselves, expressed gratitude that SCERT and the Young Inspirers were handling the dissemination of this important information. As their activities have become well known around Lucknow, the Young Inspirers are now often asked to join different kinds of public festivals and events. The overall success of the Young Inspirers has been disseminated around the world as a model of how effective peer education can be.

Why Use Peer Education?

CHAPTER TWO

"Adolescents live in a world that looks and sounds different from the world of the investigator or the funding agency. To penetrate that world involves discarding traditional notions about sampling frames and heterogeneity of focus groups. You need to reach kids on their own terms in an environment in which they feel comfortable."

(Lefebvre, C., cited in Israel & Nagano, p. 20 of 42)

The Problem

According to the World Health Organization, approximately 20% of the world's population, or 1.2 billion individuals, are adolescents; more than at any time in human history. A world average of five percent of these youths do not live at home, or in any proper 'family' environment, and in some countries the figure is as high as thirty percent. With over-population, fueled by ignorance and unwanted pregnancies, and the dire threats posed by HIV/AIDS

and other STDs, urgent action is needed to effectively alert young people of the dangers and consequences of their actions vis-à-vis their sexual conduct and reproductive health.

"Every year, at least 120 million women who do not want to become pregnant do not have the means to prevent it. Every year, 20 million women put their health and lives at risk because they seek unsafe abortions. Every year, there are more than 330 million new cases of curable sexually transmitted diseases and one adolescent in twenty becomes infected. Every year, the HIV virus infects 5.2 million people, over half of them young people below 24 years old" (Brundtland, ICPD+5 Forum, 1999).

Across the planet, adolescent sexual behaviour in virtually every country is changing. In the last few decades three trends have emerged in regards to adolescent sexual behaviour: "(1) the average age of menarche and spermarche have decreased, (2) the average age of first sexual intercourse has also decreased, and (3) the average age of marriage has substantially increased" (Kirby, 1997, p. 3).

There are other serious problems related to adolescent reproductive health that are most critical today. These include the problems of sexual abuse, incest and violence towards young people, prostitution and pornography that prey upon the young, and the illegal trans-global trafficking of young women for the purpose of sexual exploitation.

All of the above calls for a concerted multi-faceted effort, in every country, to reach out to adolescents with information and support, to warn them of the risks to their reproductive health, to provide them with methods to safeguard that health, and to provide them with access to counseling that will support and encourage them to behave sexually with care and responsibility towards themselves and others.

Peers and Peer Groups

There is a generally held belief among adults that peer groups and peer group pressures exert a negative influence on their children. However, an American study commissioned by The National Campaign to Prevent Teen Pregnancy that sought to look at relationships that influence the timing of a girl's sexual debut obtained some surprising results. Among the findings were that "(1) much peer influence is positive, (2) having older friends of both sexes increases a girl's risk of pregnancy, and (3) best friends and the leading crowd – the "in crowd" – are less influential than we ordinarily assume" (Bearman; Bruckner, 1999, p. 1).

While acknowledging the difficulties in isolating such social and relationship influences, this study focused on relationships defined as "single best friends", "network of close friends", the "peer group or clique", the leading or "in crowd" for the school, and finally, the school as a whole. What it found was that "the effects of best friends on sexual debut were *very small*" (Bearman; Bruckner, 1999, p. 21). The network of close friends is more influential than the single best friend, but usually in a positive, supportive way, unless the friends in the network are older (Bearman; Bruckner, 1999, p. 22). It also found that the larger world of the peer group or clique that the young person is associated with is important, but often has a negative impact. And finally, the "in crowd" and the whole school did not seem to have much impact.

Why Peer Education?

The point of citing the study, mentioned above, is to counter the often-held belief that all peer influences are negative. They are not. In fact, as this study and others have shown, peer influences are very often positive. One of the things that peer education tries to do is to recognise the power of peer groups in the world of the adolescents, and to use that influence to impact their lives in a positive way. "Adolescents are more likely to follow their peers and engage in 'neutral' or

pro social behaviours than in anti-social behaviours...evidence indicates that adolescents feel pressured to be involved with their peers and do not necessarily feel pressured towards misconduct" (Heaven, 1994, p. 86).

Again, peer education is not intended to be an isolated intervention; it is intended to be one important part of a comprehensive, co-ordinated effort to help lead adolescents towards making their own wise and responsible decisions.

The underlying assumption of peer education is two-fold. First, there is the "reluctance of young adults to confide in adults" (Israel and Nagano, n.d., p. 15 of 42). Secondly, this is one very significant way in which adolescents learn and communicate; they learn from each other. Peer groups "provide a context for sociable behaviour, the exploration of personal relationships and a sense of belonging" (Heaven, 1994, p. 79). In doing so, they provide an opportunity for adolescents to learn about sexual behaviour from each other. The on-line magazine, *Advocates for Youth,* reports that "studies show that adolescents who believe their peers are practicing safe sex are more likely to be influenced to do the same" (Advocates for Youth, n.d., p. 2 of 4).

A baseline study conducted in the Philippines found that "due to the unavailability of support services in the communities, adolescents when confronted with problems usually sought the help of their friends or [kept] their problems [to] themselves" (de la Cruz, 2000, p. 6). Most adults can cast their minds back and remember how it was for them, when they were adolescents. In fact, in the past, most adults probably learned more about sex and reproductive health from each other than they did from anywhere else. The problem is that the information that was being passed around was not always reliable or helpful. A lot of myths and misinformation came through adolescent peer group channels in the past. Peer education attempts to put those channels to better use by supplying accurate information through select, trained peer educators.

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Along with what is generally known as 'peer pressure', role modeling is a natural function of peer groups; members often mimic the behaviour of their peers. "Without saying anything directly to a teen or expressing an expectation about the adolescent's behaviour, a peer may have substantial influence simply by showing what to do and how to do it" (Bearman; Bruckner, 1999, p. 29). Another way that peers influence each other is by "structuring opportunities", planned circumstances beyond the supervision of adults, where the peer group itself "sets and enforces group norms" (Bearman; Bruckner, 1999, p. 30).

In this way, peer education appeals to common sense. It seeks to effectively utilise that which adolescents do most naturally: learn from each other. And, anecdotally, its impact is considered to be extremely effective. The problem is that evaluations are difficult and expensive to conduct. It is especially difficult to isolate the influence of the peer education strategy when it is one part of a larger and more comprehensive programme. Process evaluations that have been conducted, and which will be taken up in the next chapter, largely suggest that peer education works well and is an important component of a broader, multi-faceted approach. Some impact evaluations have been conducted, but relatively few considering the hundreds of applications of peer education underway around the world. The following chapter will deal with research into the effectiveness of peer education programmes.

Advantages and Benefits of Peer Education

Some advantages and benefits of peer programmes (Pathfinder International, 1997) include the following:

- They build on evidence that young people already get a lot of their information from their peers.
- Adolescents relate well, perhaps best, with those similar to themselves in age, background and interests, i.e. their peers.
- That peer educators are of the same culture means that the language and messages used are relevant.
- Peer programmes can help change social behaviour.
- Compared to other strategies, peer programmes are relatively inexpensive.
- Peer programmes often reach beyond the target population and into the family and the community as a whole.

- Peer educators often gain long-term benefits from their experiences. These include an ongoing commitment to responsible reproductive health behaviour, leadership, job training and experience.

What Research Says About the Peer Approach

CHAPTER THREE

Research has been conducted to try to ascertain the effectiveness of different peer education approaches and to find out which approaches are the most successful. Still, more research is necessary, especially long-term impact evaluations. "While hundreds of evaluations have been carried out, few evaluations involved rigorous research designs and collection of behavioural and biological outcome data" (Population Council, June 2000, p. 2).

Still, there is an overwhelming amount of anecdotal evidence, as well as outcome measurements, indicating the positive effects of applying a peer education strategy to issues related to adolescent reproductive health. One of the problems with conducting evaluations of peer education is that it is rarely employed as an isolated strategy; peer education is almost always embedded in a comprehensive effort. A review conducted by the Population Council found that the "vast majority of organisations participating in their needs assessment reported that their institution had

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integrated peer education with other programme activities in an effort to prevent HIV infections" (Population Council, June 2000, p. 7). Similarly, "Peer education is rarely used alone in HIV-prevention efforts, but is one strategy in a school-wide or community-wide effort" (UNICEF, n.d., p. 1 of 4).

Activities that are often complementary to peer education efforts include: condom distribution; social marketing; counseling; STI/HIV testing; information dissemination; education and communication campaigns; drama/theatre, amongst others. These efforts are also complemented by formal education and public awareness campaigns. Such integration makes it very hard to isolate the impact of the peer education component. However, it has been reported that it is the peer educators in this comprehensive system who link all of the inter-related activities together (Population Council, June 2000, p. 7).

There are three types of evaluations that can be applied when studying programmes and services like peer education. They are:

1) Process Evaluations – These are conducted while the programme is running to determine if the programme has reached its target population, that it is delivered as intended, and whether it has been properly funded. More formally, a process evaluation analyses the dynamic processes at play during the project implementation, identifies problems, and notes outside influences, so that they might be better taken into account.
2) Outcome Evaluations – These evaluations measure participants' short-term knowledge gain, and the programmes' effects on short-term attitudes and behaviours. They measure and note the end products of an intervention, i.e., how many were trained, what was the increase or decrease of a particular behaviour or attitude as compared to the baseline measurement taken at the onset of the project, etc.

3) **Impact Evaluations** – This type of evaluation measures long-term (one to five years) effects of the programme or intervention to determine whether implementation has met the programme goals (adapted from Advocates for Youth, "Programmes at a Glance", n.d., p.1).

For evaluations to be relevant, proper baseline studies need to be conducted prior to project implementation. In this way comparisons of pre- and post-interventions can be meaningfully made. One excellent example of such a baseline study is available in the *Illongos for ARH Project: A Baseline Study on Adolescent Reproductive Health,* submitted by Julieta R. de la Cruz, Director of the Institute of Maternal and Child Health in the Philippines.

Effects of Peer Education Applied to Adolescent Reproductive Health (ARH) Issues

Peer education has found many programme and project applications all around the world, and, in many of them, studies have been conducted. Although these studies are mostly process and outcome evaluations, they still give an indication that the peer-to-peer approach is natural and effective, especially in increasing levels of knowledge. What is unclear due to the scarcity of long-term studies is how much the peer education intervention has changed behaviour in the long term. Nevertheless, these studies have found that peer-assisted interventions "enhance HIV knowledge and decrease risk behaviours" (Advocates for Youth Fact Sheet, n.d., p. 2 of 4).

The urgency of the HIV/AIDS epidemic has mobilised many programmes throughout Africa. Many of the projects, either implemented or reported by UNAIDS, utilise peer counselors as a key part of their overall strategy. They all report that peer educators have had

considerable positive impact. In addition, their outcome reporting indicates that thousands of young people have, at least, received the message, a message that includes where to go to get further information and counseling advice. The African countries where such efforts have been reported include: Cameroon, Kenya, Burkina Faso, Ivory Coast, Botswana, Ethiopia, and Zambia, to name just a few (See UNAIDS Reports).

Ghana

An instructive pilot study of a peer education effort is found in Ghana. While the study confirms the positive advantages of applying peer education, it also found that in the culture of the target group, families were a very high source of adolescent reproductive health information. Therefore, its recommendation is to include the family as part of the overall intervention. The pilot study found (Wolf, Tawfi, and Bond, June 2000, pp. 61-80):

- Peer educators tended to reach peers of their own gender, but there was considerable crossover as well.
- Peer educators tend to reach peers similar to themselves, for example, by age, religion, ethnic background, social clubs, schools, and interests.
- Peer education encounters can happen in many different settings, though the most common was in schools. Nearly half of the encounters involving peer educators were with their friends.
- Young people in Ghana tend to seek advice on issues related to adolescent reproductive health from their families first (53%) and their friends second, (42%). Therefore it was considered necessary to build the family into the loop of the intervention.

This study underscores three valuable points: first, peer education is effective at reaching a target audience very similar to the peer educators; second, there are often other factors that also can be effective and that should be brought into the intervention; and third, carefully setting the intervention to the context of the target audience is essential (See Lessons Learned).

Cambodia

A process evaluation of the Youth Reproductive Health Initiative, implemented by the Reproductive Health Association of Cambodia (RHAC), indicated very positive results were being achieved, and noted recommendations for improvement. The Youth Reproductive Health Initiative, a pilot project involving a peer education programme, was implemented in Phnom Penh, Sihanoukville, and Battambang in 1999. In this initiative, high school students were trained to provide reproductive health information to their peers, both in and out of school. At the same time, health clinic services for youth were established at the same locations. These clinics were provided with a waiting room/library for youth to find access to health information in the form of books, magazines and audio-visual materials.

The major results of the project (Chowen, n.d., pp. 4-6) for the period of 1 January 1999 to 31 December 1999 are noted below:

- The implementation of youth-friendly clinics was reported as "excellent", with youth responding to the friendly, non-threatening environment provided;
- Both Youth Project Assistants and peer educators were actively involved in conducting educational activities, utilising the waiting room/libraries at the clinics;
- Youth attending the sessions reported that they feel comfortable discussing sexual health issues with the staff and peer educators, and they enjoyed coming to the library.

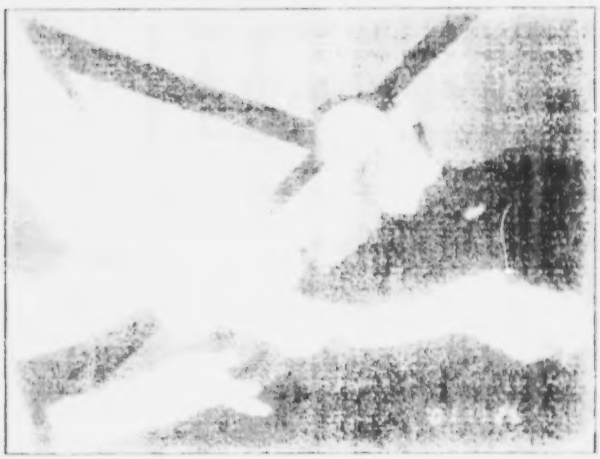
Some problems/constraints were also noted in this evaluation. Some of the professional staff reported that they were still learning how to talk to youth about reproductive health issues, especially concerning certain topics. It was also noted that while the libraries were being well used, they were in need of more materials appropriate for youth.

Concluding, the consultant noted, "The RHAC youth programmes and services have already made a considerable impact in terms of the increased

numbers of young people presenting [themselves] for reproductive health services, and in raising community awareness of young people's sexual and reproductive health needs. Perhaps for the first time, people are beginning to talk openly about these issues and to acknowledge the problems facing young people" (Chowen, n.d., p. 17).

China

The following final evaluation of an ARFH Pilot Project implemented by the China Family Planning Association reported "strong evidence that the pilot project was successful in testing a variety of styles and methods to raise sexual health (SH) awareness amongst youth, with the evaluation showing that many of the interventions were appropriate and systematic in design and rich and fitting in content, having an obvious effect on knowledge and attitude levels and a profound and lasting influence on both students, teachers, parents, health/FP workers and policy makers" (UNFPA/CFPA, 2001, p.2).



The pilot project was implemented in Minghan District (Shanghai) and Haidian District (Beijing), beginning in 1998. Its long-term goal was no less than "the achievement of the national plan for socio-economic development and improved quality of life through better S/RH for Chinese youth" (ibid. p. 2). Peer educators were not only the primary vehicles of the intervention, they were also the project evaluators. After intense one-day workshops, eight student peer educators from each district were "equipped with the necessary tools to conduct a series of focus group discussions and in depth interviews" (ibid. p. 4). They also gathered quantitative data from survey instruments that was later analysed using SPSS, and qualitative data through the focus groups and in-depth interviews. Unfortunately, the base-line survey in Beijing was not available for comparison, so they were left with qualitative results to consider.

In both districts, peer education was central to the intervention, and focused on such diverse issues as decision-making, HIV/AIDS, avoiding drugs, and sexual health. The immediate objectives of the interventions were (ibid. p. 6):

- To provide appropriate information to the students;
- To create a healthy environment within the schools; and
- To empower students, assisting them in their personal development over this crucial stage in their lives.

Once selected, the peer educators conducted over 130 peer education sessions in Minghan District alone. A student-run newsletter was printed in seven issues, and a video was made showing students running peer education training and other activities. In all, the evaluation results indicated that the pilot project was very well received by students, teachers, parents and health/FP workers. (ibid. p. 6) They also showed that the intervention helped "eradicate the 'fear' of AIDS and prevalent negative attitudes towards people living with AIDS (PLWA)...with...90% of the students respond[ing] that they would be happy to live and study with PLWA" (ibid. p. 7).

Findings from both implementations also showed that the peer education strategy of employing a variety of innovative styles, including focus group discussions, role plays, games and informal discussions was successful in "attracting students' attention; gaining their participation; eradicating generation barriers; and encouraging creativity, imagination and discussions...*with*...84% of the students hoping that they could continue the peer education activities" (ibid. p. 7).

Qualitative results of the evaluation found that a large majority of students felt that their levels of knowledge of adolescent reproductive health issues had increased. They also reported that "their ability to make decisions had improved and this had helped them to mature" (ibid. p. 9). Significantly, 80% of those surveyed in Minghan said that trained peer educators were the best sources of sexual health information for

the following three reasons: "easy to communicate with peers; can empathize with students; and provide security" (ibid. p. 9).

From the evaluation administered by the select peer educators, the Adolescent Reproductive Health Pilot Project was said to be an overwhelming success. As a lecturer at People's University (one of the target schools) said:

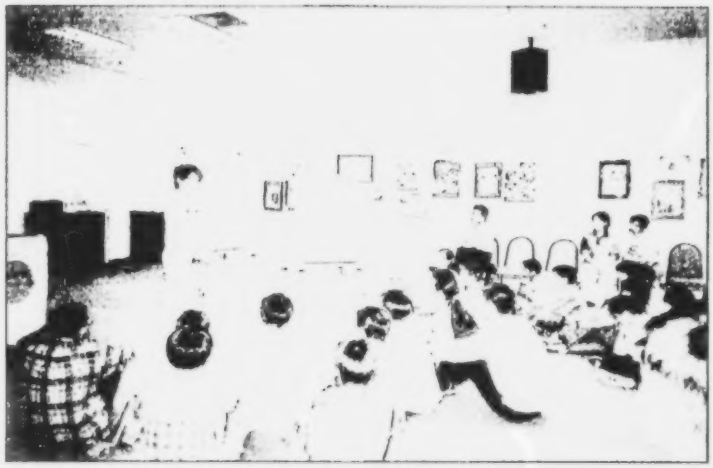
[Peer education] followed the principle of equality and was a learning process for everyone involved, wide-reaching, effective and it furthermore broke down the taboo of not being open about sex in the classroom. Peer education is of monumental significance which can have a great impact on the whole of society and gives a useful direction for young people" (ibid. p. 21).

Influences on the Issues

While the direct influence of peer education is difficult to pin down because of the integrated nature of its typical application, many projects attribute much of their success to the innovative approach. Peer education is widely held to have a positive influence on issues related to adolescent reproductive health, such as pregnancy prevention, STD/HIV/AIDS prevention, and overall knowledge of ARH.

1. *Influence on Teen Pregnancy Prevention*

Peer education has long been applied in efforts to reduce teenage pregnancy. Specifically to address family planning issues in Burkina Faso, Eritrea, Senegal, Zambia and Zimbabwe, peer educators were trained and employed as part of the Family Planning Service Expansion and Technical Support (SEATS) Project, which was conducted from 1995-2000. Claiming success for the approach, the SEATS Project also trained peer educators in Albania, Russia and Cambodia.



Typically these efforts are combined with a comprehensive adolescent reproductive health strategy that usually includes teaching safe sex practices, contraception and STD/HIV prevention. The results from an important long-term evaluation of the West African Youth Initiative in Nigeria and Ghana indicated that "the target population showed increases in knowledge and in the use of modern contraception methods, when compared to the baseline survey", and more were taking protective measures against STD/HIV (Magnani, n.d., p. 2 of 6).

Adapting the peer education approach to fit local contexts and needs is an important aspect of strategy planning that must precede implementation. In India, one model for teaching the Family Life Education curriculum is to provide training to both teachers and peer educators by external resource persons. The peer educators later take charge of students under the supervision of the nodal teachers (Anderson, A., Kumar, S. and Petersen, J., 1996).

2. *Influence on STD/HIV/AIDS Prevention*

For the last twenty years, the most common application of peer education has to do with STD/HIV/AIDS prevention. Still, these efforts combine overall ARH knowledge dissemination, contraception and family planning, and drug use prevention. STD/HIV/AIDS prevention also focuses on the practice of safe sex, including the proper use of condoms, celibacy, and single partner relationships. The following are some examples of research indicating the influence of peer education on the STD/HIV/AIDS epidemic:

- An instructive example of sex worker peer education intervention was conducted in Chiangmai, Thailand. This effort was aimed at the owners and managers of brothels as much as it was at the sex workers themselves. First, sex workers were selected and trained as peer educators. They then encouraged brothel owners to insist on mandatory condom use through a 'model brothel' programme,

part of which called for the Thai government to provide free condoms. As a result of this effort, the percentage of "sex workers refusing sex with clients who did not want to use a condom (even when the client offered more money) increased from 42% before the intervention to 78% one year afterwards" (UNAIDS, 1999, p. 26). This example illustrates the need to enlist the support of all stakeholders, especially for interventions affecting the sex industry.

- In Nairobi, Kenya, peer counselors have been trained and mobilised in different projects to address a variety of concerns. Beginning in 1987, young people in Mathare, the largest slum area in Nairobi and infamous for crime, drugs, poverty, prostitution and AIDS, have been effectively implementing many community projects, ranging from environmental cleanups to an HIV prevention campaign. It is estimated that 20,000 young people were reached with reproductive health information and services through the programme between 1994 and 1997 alone (UNAIDS, "Youth in Kenya", n.d., p. 2 of 3).

- In Yunnan, China, peer education was employed in a project to prevent the spread of HIV/AIDS among young people. An independent appraisal group found that the use of peer educator/facilitators had proven very effective in getting their message out to the target population and beyond them to their families (UNAIDS, Yunnan, n.d., p. 3 of 4).

- Results of a CAPS study, conducted through the University of California at San Francisco, on a programme that targeted high school age Latino youth, showed that the "intervention group reported higher levels of AIDS/STD knowledge" (Center for AIDS Prevention Studies, n.d., p. 2 of 2). While there was an increase in sexual activity noted, there was a similar increase in condom use.

- The CRUSH programme (Community Resources for Under 18s on STDs and HIV), in Kenya, collected survey results that showed that the target group of out-of-school youth displayed "better knowledge, more positive attitudes, and signs of behavioural changes toward STD/HIV prevention following a peer-to-peer educational intervention" (Pathfinder, 1997, p. 2 of 3).

3. *Influence on Overall Knowledge of Adolescent Reproductive Health*

Most applications of peer education combine many different messages concerning adolescent reproductive health. Outcome evaluations of most projects clearly indicate an increased level of awareness and knowledge about ARH. For instance, an evaluation of the West African Youth Initiative in Nigeria and Ghana "indicates significant positive effects of programme participants' knowledge, perceived self-efficacy, and behaviour" (Pathfinder, 1997, p. 2 of 3).

A peer education effort in Sri Lanka reported that over 50,000 adolescents in predominantly rural areas had been reached with information concerning adolescent reproductive health issues. (Abeysinghe, n.d., p. 2 of 3) A similar effort in Cambodia reported that 2000 young people had received critical ARH information through just one activity of its Youth RH Programme (Beaufils; Kent, n.d., p. 3 of 3).

In a large-scale intervention in New Delhi, India, the PERANA project, Phase-II was implemented in 100 schools and involved 10 NGOs. Peer educators were used in the effort to get HIV/AIDS information to their peers and also to sensitise principals, teachers and parents to HIV/AIDS issues. Pre- and post-test results indicated that overall ARH knowledge for both boys and girls had increased (PERANA, n.d., pp. 9 and 18).

UNICEF and the Government of Namibia launched the "My Future is My Choice" campaign designed to "reach young people through young people" (UNICEF, n.d., p. 4 of 4). The purpose was to bring ARH information and knowledge about the availability of ARH services to youth. So far, more than 600 peer educators have been trained, reaching more than 50,000 of their peers.

In 1994, as part of the Asian Red Cross/Red Crescent AIDS Task Force (ART), UNICEF teamed with the Myanmar Red Cross Society to implement a Red Cross Youth Peer Education Programme (Myanmar). This on-going effort has reported nearly 1000 trained facilitators and peer educators, and over 35,000 young people reached with information and counseling. Preliminary evaluation findings suggest an increase in knowledge and awareness of STD/HIV (UNAIDS, n.d., Myanmar).

4. *Influence on Peer Educators: Their Knowledge and Behaviour*

Peer education really has two target audiences: the peer group and the peer educators. Studies that have focused on the increase of knowledge and changes in behaviour of peer educators, have indicated that the overall impact of the strategy is strongest on them.

- A 12-month impact evaluation conducted on a peer education effort in Georgia, USA, found that the peer educators themselves increased their use of condoms at a rate eight times more than the control group (Advocates for Youth, "Evaluated", n.d., p. 3 of 5).

- In Jamaica, the "Together We Can" Project reported that peer educators had significantly gained in knowledge about HIV transmission and services (Pathfinder, 1997, p. 2 of 3).

- The World Health Organization (WHO) reports that peer education has proven to be an extremely important means to communicate essential messages relating to adolescent reproductive health. In one study of 21 projects worldwide, it was reported that 95% of the peer educators had themselves changed their own behaviour (WHO, n.d., p. 1 of 7).

- As reported by the on-line magazine, *Advocates for Youth*, peer-assisted programmes often note that the peer educators themselves report a change in their own behaviour (Advocates for Youth, "The Facts", n.d., p. 2 of 4).

- And in Mexico, the PROJUVE project showed that peer educators had significantly changed both their attitudes and behaviours (Pathfinder, 1997, p. 2 of 3).

5. *Comparing Peer Education to Traditional Approaches*

Some surveys have been conducted as part of project evaluation that have confirmed that young people prefer receiving adolescent reproductive health information from peers, as opposed to from adults or in a traditional school setting. They have also indicated that the peer education programmes are more effective.

- According to *Advocates For Youth* on-line journal, studies comparing "peer-led versus adult-led education programmes have found that peer counselors produced the greatest attitude changes related to the adolescents' perception of personal risk of HIV infection and improved their inclination to help prevent transmission" (Advocates for Youth Fact Sheet, n.d., p 2 of 4).

- A peer education intervention in a factory-based setting in Thailand that targeted single, female adolescents, proved to be significantly more successful than sessions employing materials only, or sessions led by adult health educators (Family Health International, n.d., p. 2 of 6).

- And, young people counseled by a peer have been found to be more likely to engage in an interactive discussion following a related educational presentation that those counseled by professional health care providers (Advocates for Youth Fact Sheet, n.d., p 2 of 4).

6. *Influence on Attitudes and Tolerance*

One important benefit of peer education efforts relating to adolescent reproductive health issues is the reported change in attitudes and values of both the participants and the peer educators. This would seem to indicate that an increase in knowledge leads to tolerance and understanding and, hopefully, even to compassion and empathy.

- Results of the same CAPS study noted above, conducted through the University of California at San Francisco, also reported decreased levels of bias towards social and gender roles in general, and homosexuality in particular (Center for AIDS Prevention Studies, n.d., p. 2 of 2).

- Similarly, the evaluation of the on-going Red Cross Youth Peer Education Programme (Myanmar) also noted above, suggest ... a more tolerant and understanding attitude towards those afflicted with such diseases (UNAIDS, n.d., Myanmar).

Lessons Learned

CHAPTER FOUR

Some lessons learned from the application of peer education to adolescent reproductive health information and services are likely the same lessons that might be learned from any kind of large-scale intervention. Peer education programmes need support from many quarters in order to be successful. They need external funding assistance that should include provisions for proper and on-going evaluation. At the same time, they need grassroots support at the levels of the community and local government. And, they need thoughtful planning and focus to reach a given target audience.

The following is a collection of "Lessons Learned" from the application of peer education in many different efforts regarding adolescent reproductive health issues. These lessons are from around the world and reported by many different kinds of organisations engaged in this effort: NGOs, local governments, and community organisations.

Overall Lessons Learned

A review of many different applications of peer education reported by *In Focus* concluded with the following list of lessons that could be derived from these many experiences (Pathfinder, December 1997, p. 3 of 3):

- Many young people prefer to receive reproductive health information from peers rather than from adults.
- The involvement of peer promoters significantly increases referrals for contraceptive services at a fixed site.
- Peer promoters need to be selectively recruited, adequately trained, supervised, and supported.
- Interactive training improves project outcomes.
- Peer counseling requires more complex training and supervision than peer education. Turnover is a common problem in peer programmes but it can be partially addressed by careful selection, the use of contractual agreements, and by good support, reinforcement, compensation, or other rewards.

A study sponsored by AIDSCAP of 21 peer education projects in ten countries in Africa, Asia, Latin America and the Caribbean identified the need for (UNAIDS, 1999, p. 7):

- initial and reinforcement training of peer educators;
- continuing follow-up, support and supervision;
- clearly understood expectations of the peer educator's role; and
- continued incentives and motivation strategies.

As mentioned in the research findings in Chapter Three, one of the most striking lessons learned from the application of peer education is that the first beneficiaries are the peer educators themselves. Not only do they report positive changes in their own knowledge, attitudes and behaviours, the skills they learn through the initial training and follow-up workshops provide them with real life skills that will help them as they grow and mature. Society and the community likewise benefit by providing special training for its future leaders, and bringing those leaders up with a sense of responsibility to serve the community with commitment and work.

According to WHO, the "ideal peer educator (and counselor) is respected, charismatic and literate. He or she has good communication skills and an interest in self-enhancement. Peer educators are often chosen by the members of a target audience because they are already viewed as

leaders and role models. Peer educators may work with individuals or groups in a variety of settings and may use teaching aids such as videos or drama" (WHO, n.d., p. 1 of 7).

1. *Peer educators need to be involved in all aspects of project development*

Most successful interventions, of any kind, call for the inclusion of all stakeholders to be involved through all phases of the project development and implementation. This holds doubly true for applications of peer education. Peer educators need to be involved in all aspects of project development for several reasons: first, to ensure that the intervention is properly set in the context of the target population; second, to ensure that the "language of youth" is properly used in all communication efforts; and third, to ensure that the peer educators have a vested interest, a sense of ownership, in the overall effort.

A three-year baseline study on ARH, conducted in the Philippines, carefully included all potential stakeholders in its research and development phase. To determine community attitudes and levels of knowledge, 14 focus groups, involving 100 adolescents, along with 50 one-on-one interviews with adolescents, were conducted to establish baseline data. This is the kind of pre-planning that is necessary to do in order to judge results at the project's conclusion. This is also an excellent example of involving young people in the initial development of the project (de la Cruz, 2000, p. 2).

Evidence of the value of including peer educators in all aspects of a project, can be seen in a report of an intervention conducted by the Jamaican Red Cross Society. They found that having the project staff, including newly trained peer educators involved in the evaluation provided instantaneous constructive feedback into the content and process of the project (Kauffman, 1997, p. 2 of 5).

To address the problem of turnover among peer educators, peer educators themselves have suggested that they need to be involved in all stages of the project development, including decision-making and evaluation. They also need to have incentives, such as personal and professional growth opportunities, built into the programme. A project conducted in Yunnan, China, with the assistance of the Australian Red Cross noted in Lessons Learned that the planning processes, "such as developing materials, can serve as valuable opportunities for young people to practice facilitation skills and to gain HIV prevention knowledge (UNAIDS, Yunnan, n.d., p.4 of 4).

When seeking information and input, it is often most useful to "go to the source". In terms of adolescents and how to most effectively reach them, and in terms of peer educators and how to most effectively recruit them, the adolescent peer educators ARE the source. As a further example of potential benefits of involving peer educators in all aspects of a project, the following valuable suggestions came from peer educators and others to address the problem of peer educator turnover (Population Council, June 2000, p. 11):

- Create partnerships with the intended audience and other stakeholders to select peer educators.
- Develop and utilise clear criteria for the selection of peer educators.
- Design a manageable scope of work for the peer educator to improve retention rates.

- Offer compensation based on context-specific standards and values. Make sure compensation given to peer educators is not so great as to create social distance between them and the peers they are trying to reach.
- Assure peer educators ongoing access to programme material, resources, and updated information.
- Conduct periodic individual and group support sessions with peer educators to address stress, burnout, and other psychological aspects as well as to share successes and ideas.
- Provide peer educators with responsibilities and decision-making power in the design, implementation, and evaluation of the programme.
- Create personal and professional growth and development opportunities within the organisation for peer educators.
- Develop a plan to gradually pass control and maintenance of the programme to "peers" and the community.

2. *Training and implementation should be participatory, set in real environments, and properly funded*

It is important that the training of peer educators happens in a real-life environment, and not just in a classroom with abstract discussions and an arsenal of facts. Participatory training methods are highly recommended. Lessons learned from the Save Your Generation Association (Ethiopia) suggested that youth are "easily bored by health messages disseminated through meetings and formal occasions...[but]...if the messages are disseminated in a participatory manner using puppet drama, and in an entertaining environment through music and songs, youth attendance at educational events is greatly improved" (UNAIDS, Ethiopia, 2-3 of 3).

It should go without saying that training programmes for peer educators must be properly funded. However, with limited resources, sometimes efforts have tried to save money on the training and focus more on the delivery stage (after the training). Yet this can lead to overall failure of the programme. If a peer training programme is not properly funded, many training problems can arise. One person put it this way:

"The nature of training that is given to peer educators is abstract. They are trained in hotels with flip charts but when they go to the community they find a totally different scenario. They are unable to fully put in practice what they have been taught for they don't have the teaching aids for

demonstration and materials to distribute" (Population Council, June 2000, p. 12).

3. *Peer educators should use the language of youth*

Most applications of peer education are based on the following axiom: Peer educators are a more reliable source of information for young people than adult educators because they communicate in the language of their youth culture and they serve as positive role models. "In the language of youth" means behaviour as much as it means verbal communication. As reported in *Advocates for Youth* on-line magazine, "studies show that adolescents who believe their peers are practicing safe sex are more likely to be influenced to do the same" (Advocates for Youth, n.d., p. 2 of 4). *YouthNet*, an on-line adolescent health journal, agrees, "Many young people prefer to receive reproductive health information from peers rather than from adults. The involvement of peer promoters significantly increases referrals for contraceptive services" (Family Health International, n.d., p. 1 of 6).

4. *Continuous and sustained training is most effective*

Training for peer educators needs to be an on-going process. Refresher training sessions should be offered periodically. At the same time, in order to sustain the interest of long serving peer educators, more advanced training should be offered. This can become an important incentive for young people becoming peer educators in the first place, and for their continued participation.

Lessons learned from the Thai Youth AIDS Prevention Project (Thailand) found the following:

"Continuous weekly training sessions proved to be critical for the peer educators. One long intensive training is not enough" "It was found useful to ask the educators to take time to invent their own games, based on the knowledge and skills they had acquired from trainings" "It is important to hear what the educators are saying...it is equally important for them to be listening to what their groups in school are saying" (UNAIDS, January 2000, p. 2 of 4).

It should be kept in mind that adolescence is a busy time of life – including for those who become peer educators. Young people have many different activities, involvements, responsibilities and commitments between which to make choices. These include school, family, friends, sports or other extra curricular activities, clubs, special interests, and relaxation and entertainment. These are all real and legitimate concerns for any young person to try to keep in balance. It often happens that, after a certain period of time as a peer educator, a young person decides to give up that involvement in order to do other things. To counter this natural problem of turnover with peer educators, it is necessary for project sustainability to have a continuous process of recruitment and initial training underway for the duration of the project. Only this will ensure continuity when some project peer educators decide to resign.

5. *Having a co-ordinator facilitates effective implementation*

An important administrative lesson was picked up from an on-going programme in Denmark called "Peer Educators for Youth People". This programme reaches 10,000 young people each year. Their experience noted that "it is essential to have a central person who is in charge, to inform the groups of new things, and prepare activities such as prepare courses, study visits, and so on" (UNAIDS, Peer Educators for Young People, n.d., p. 2 of 2).

6. *Special needs communities can be reached*

In Europe, the Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe Project (TAMPEP) is active in Austria, Germany, Italy and The Netherlands. The project employs peer educators who are themselves sex workers and who can translate the health messages by language, national or ethnic culture, and sub-culture. The experience of TAMPEP has been that peer education alone is not enough to reach the goal. It must be used as part of a comprehensive effort that includes "seminars, workshops and other field activities aimed at empowering sex workers and provide them with a supportive environment for safer behaviours".

Lessons learned from this intervention (Baldo, 1998, p. 2 of 2) include:

- Peer education programmes should be placed in a broader context of promoting esteem, health, safety and civil rights, including protection of the rights of migrant workers.
- Peer education programmes should be carried out using autonomous community-based organisations as a base.
- The sex work scene changes continuously, so peer education models and programmes should be continuously adapted to these changes.

A project utilising peer educators to reach commercial sex workers (CSWs) in the Philippines reported positive initial results. They noted "significant changes in knowledge, attitudes, and self-efficacy of CSWs and managers...*and*...significant improvement in STI clinic attendance" (UNAIDS, 1999, p. 21).

A peer education programme to address the issues of sexual abuse, STI/HIV/AIDS, and unplanned pregnancy, was initiated by the Ministry of Youth Affairs of New Zealand. The programme was designed to specifically focus on the needs of Maori and the Pacific peoples. They found that an ideal strategy to reach the intended audience linked four interconnected social environments, family, school, community, and peer groups. It also used "multiple and coordinated initiatives and offers opportunities for young people to participate in identifying their own needs" (Ministry of Youth Affairs, 2001, p. 21).

7. *Working with teens ensures success*

After reviewing several studies, the National Campaign to Prevent Teen Pregnancy noted some important lessons for programmes to consider (SIECUS, 1999, p. 2 of 2):

- Try to make use of all types of peer influence in intervention programmes. Help adolescents differentiate positive from negative peer influences and learn to negotiate effectively among them.

- Recognise that individual teens may live in significantly different peer cultures. Broadly focused interventions may have limited success when teens divide themselves into discrete subgroups with different norms and leaders.

- Consider using naturally occurring peer groups in productive ways. If the most influential peers are those that teens select in their close circles and larger cliques, encouraging positive behaviours in existing groups may be more effective than creating new groups, as many programmes try to do.

- Peers may have more impact on girls than boys. More than one study suggests that girls are more oriented to peer relationships than are boys and, therefore, are more receptive to messages delivered by peers.

- Be aware of the added costs associated with peer-led programmes, including training, supervision, and transportation, as well as the need to constantly replenish the supply of teen leaders.

8. *Gender considerations are important*

Sometimes there are necessary gender considerations to be taken into account in the effort to reach certain populations. It has been found in some cultures, that men, especially young men, are reluctant to admit their ignorance about sexual matters. This can sometimes be compensated for in different ways depending on the cultural context of the intervention. For example, projects implemented in Viet Nam have shown that female adolescents can be very effective in encouraging male adolescents to participate in discussions on reproductive and sexual health.

In other countries, it has proved useful to provide male peer educators specifically to get messages to a male target population. A programme called "Man Talk" in Swaziland trained men to talk to other men in bars, pool bars, clubs and factories. They also distributed leaflets of information as well as condoms. (Cohen; Burger, 2000, p. 103) Projects that specifically train male peer educators to communicate with young men have been implemented in Mexico, Ghana, Jamaica, and Namibia. In Mexico, peer educators of "Gente Joven", a MEXFAM project, report, "as a result of project activities, more young men are seeking information about contraception" (Cohen; Burger, 2000, p. 152).

9. *Set the intervention in context*

Addressing the need to set the intervention in its proper context, respondents to a UNAIDS study indicated the need for them to learn more

about how to conduct community needs assessments, "with specific attention to socio-cultural and ethnographic assessments, with a given population in order to better respond to target population and community needs as well as to create strategic plans based on assessment results'. (UNAIDS, 1999, p. 15)

Not all applications of peer education have met with total success. Indeed, perhaps the best way to learn how to improve any programme or intervention is to carefully consider its shortcomings or failures. The following examples underscore the need to set the interventions carefully within the socio-cultural context of the target population. To fail to do so will likely result in failure of the overall effort. "We have learned that just providing information about HIV and protection isn't enough. Prevention messages and implementations need to be adapted to specific cultures, sub-groups, lifestyles and age" (Svenson; et al, 1998, p. 13).

A reported failure of the use of peer educators comes from a pilot study conducted by the Department of Epidemiology of the Peking Union Medical College (PUMC). The pilot study targeted young women on the island of Hainan who were involved with the local sex industry. Peer educators were identified and trained, and a women's health club was opened. However, it was soon realised that the young women had little or no motivation to participate, and so the use of peer educators was eventually dropped. There were also problems due to the nature of the girls' work; they were often not available. And, the pilot project ran into some serious resistance from some of the owners of the businesses where the girls worked. Among the lessons learned in this failed attempt to bring sexual health information to a target audience of young women, foremost is the need for a supportive environment, and to carefully contextualize the intervention. (Liao, 1998, p. 1-3)

An important lesson learned from a study conducted among young Latino high schools students, underscored the need to set interventions carefully within the socio-cultural context" of the target community. (Center for AIDS Prevention Studies, n.d., p. 1)

In El Salvador, peer education has been employed by the *Homies Unidos* programme to address problems of both street violence and sexually transmitted diseases. The programme was specifically designed to work within the gang community of San Salvador. It sought to bring together two rival gangs under a common cause. Obviously, to do this it was

necessary to work with them on their own terms, using their language, building upon their knowledge of their environment and of their particular sub-culture.

Further lessons learned from this unique peer education programme (Rose-Avila, n.d., p. 1 of 2) include:

- The importance of identifying leadership from the target population.
- Getting the information to them in a way that they can, and will, understand: their own language. Use the slang of youth.
- Programmes must make condoms readily available.
- Programmes should target young women, especially emphasising negotiating skills so they can say no to unprotected sex, reinforce their esteem.
- Programmes like this need to reach out to the wider community.

10. *Peer education can work in varied settings*

A highly significant lesson learned from the Red Cross Youth Peer Education Programme (Myanmar): It is possible to implement community-based peer education efforts in a resource-poor country on a very large scale. (UNAIDS, Myanmar, n.d., p. 3 of 4) This is not to say that implementation is inexpensive, just that it is possible to successfully conduct a peer education effort among poor populations.

11. *Youth centres can provide enabling environments for peer education*

The establishment of youth centres is often one component of a comprehensive effort towards addressing the needs of adolescent reproductive health education. Youth centres typically provide a meeting place for the dissemination of information, counseling services, and positive social activities as designed and required by the youth themselves. Often, they employ peer educators to facilitate their efforts.

As an example of the Youth Centre approach, in Sri Lanka, a programme was launched entitled, Awareness Campaign in Sexual and Reproductive Health among Adolescents. An initial survey was conducted that confirmed that most of the youth polled said that they received most of their sexual and reproductive health information from their friends. Unfortunately, all too

often, their friends did not have the correct information to work with and pass on.

Therefore, six youth centres, called *Yovun Kendraya*, were set up with local youth participating in the decision-making processes. All centres were provided with a few basics for entertainment and dissemination of information: a colour TV, a VCD player and screen, and an overhead projector for presentations. The centres themselves were most often a special room provided by the local school. Peer educators are in the process of being selected and trained (Boekel, 2002).

In 2000, Administrative Order No. 34-As, 2000, in the Republic of the Philippines, instituted a comprehensive Adolescent & Youth Health (AYH) Policy. This policy called for the creation of "One Stop Shop Adolescent & Youth Health Centres", to be accredited by the Department of Health. To facilitate the dissemination of information and counseling services, including doctor and clinic referrals, these centres are to have "available trained peer counselors and professionals or on call professional care givers" (Romualdez, April 10, 2000, p. 4).

12. *Peer education initiatives can have beneficial and unexpected side-effects*

The Trance essa rede Project in Sao Paolo, Brazil is the result of two peer education interventions coming together to form an innovative partnership. One of the peer models was employed in a slum community of Sao Paolo. The other was implemented in the public school system. The two groups were brought together and they decided to join forces into a disease prevention network project. The network idea brought youth of very different social classes together in common cause for the prevention of disease, and led to a joint advocacy programme for their rights as "citizens and social actors able to intervene in their communities" (KIT, Brazil, p. 1 of 1). In this case, the initial focus on ARH was broadened to include community involvement on a variety of social issues.

13. *On-line peer education offers greater access to target populations*

The Internet offers new ways to reach out and get adolescent health care messages to the youth who need them. Because it occurs in 'virtual space', on-line peer education and counseling offers complete anonymity.

As young people all over the world are more and more hooked into the Internet, the possibility of providing on-line service and information is an important new avenue to explore. Often different on-line sites target specific audiences. For example, one in the United States, called "My Sistahs", is for young women of colour. Other sites target young gay men, lesbians, bisexuals, and young heterosexuals. The opportunity exists to provide safe, reliable, anonymous service to everyone on-line.

Advocates for Youth, A US-based peer education effort aimed at adolescent health care needs, provides on-line peer educators. They are on-line at the following websites:

- http://www.youthresource.com
- http://www.youthHIV.org
- http://www.youthshakers.org
- http://www.mysistahs.org
- http://www.ambientejoven.org

As mentioned in the opening chapters of this review, peer education is rarely employed as an isolated intervention; it is usually one important component of a comprehensive strategy. This section takes a brief look at some comprehensive programmes that peer education is incorporated into, some alternative programmes that do not use peer education at all, and some interesting variations on the theme.

14. *Social marketing strategies which employ peer educators can be effective*

Social Marketing for Adolescent Sexual Health (SMASH)

Social marketing strategies promote health-related issues, delivering information and services to target populations, by using techniques "drawn from commercial advertising, market research, and the social sciences" (Israel & Nagano, n.d., p. 2 of 42).

Social marketing is a programme "designed to improve the health of low-income people by promoting health behaviour...offering health products and services at affordable process, and motivating people to use them" (SMASH. 2000, p. 6).

Typically, the kinds of objectives that social marketing around health issues tries to achieve include: increased use of health products, like condoms, increased access to health services, increased use of health services, and changes in behaviour, like practising abstinence or single partner sex (Israel & Nagano, n.d., p. 2 of 42).

All forms of mass media are often employed in a social marketing programme. The SMASH programme in Botswana, Cameroon, Guinea, and South Africa set its overall goal at increasing the level of awareness of policy makers and programme managers of the potential of using social marketing for issues like reducing the vulnerability of youth to HIV/AIDS. To do this, the programme combined the following activities (SMASH, p. 11):

- Radio call-in shows on adolescent reproductive health topics;
- Setting up youth clubs in schools;
- Peer education interventions;
- Setting up 'youth-friendly' clinics;
- Using informational spots broadcasts on radio and television;
- Printing and distributing t-shirts and pamphlets;
- Putting on traveling entertainment shows with music and skits, etc., that also distributed health information and products;
- Recruiting teen idols, music, film and TV personalities to help spread the message;
- Providing half-time entertainment at sporting events;
- Organising AIDS-related debates in schools;
- Putting on 'edutainment' events, like dances, music concerts, sport competitions, etc.; and
- A general mass media campaign that used radio, TV, newspapers, magazines, computers, direct mail and public advertising space.

Aimed at youth, the idea is, first, that adolescence is a developmental stage during which many behaviours are still in the process of being formed. This is why it is considered crucial to intervene at this time in a young person's life with a comprehensive programme designed to help that young person make informed and responsible choices for themselves. In 1993, The Center for Population Options reported that young adults are greatly influenced by mass media. (cited by Israel & Nagano, n.d., p. 14 of 42)

In developing countries, where many of the problems related to adolescent reproductive health are most exacerbated due to poverty, under-education,

and a general lack of health services for adolescents, it is sometimes difficult to find the youth and deliver the message. That is why all possible avenues through which to get the message out must be made, and where social marketing comes in.

Peer education is an important part of any comprehensive social marketing strategy. Peer educators might find themselves 'performing' in some youth-targeted show at local retail outlets, for example. Or, they might find themselves handling shifts on a telephone hotline service that provides information and emergency counseling. Telephone hotlines work well because they offer complete anonymity.

Peer educators are also well used in the planning stage of a comprehensive social marketing strategy. They know from their personal experience, as youth in the community, how to communicate the messages to adolescents.

Social marketing projects have been implemented around the world and have showed very positive results in post-project outcome and impact evaluations. One possible drawback is that they require a considerable commitment of resources. The following is a brief listing of seven key design principles that should be considered when planning a social marketing campaign (Israel & Nagano, n.d., pp. 3-4 of 42):

- Effective interventions address not only the behavioural issues of young adults themselves, but also environmental factors and social norms that greatly influence young adult reproductive health behaviour.
- Involving key gatekeepers and stakeholders at the outset is a critical project success factor.
- Young adults need to be involved in all aspects of social marketing reproductive health interventions.
- Media advocacy activities are an important complement to social marketing interventions.
- Pre-testing of all messages is essential, especially those transmitted through mass media channels of communication.
- Relevant supportive networking and training activities need to be carried out throughout the life of the project.
- All major projects should include a well designed evaluation component.

To gain a more complete overview of current trends and practices, the FOCUS on Young Adults Research Series has the complete paper by Ronald Israel and Reiko Nagano available on the Internet. The paper, entitled, "Promoting Reproductive Health for Young Adults through Social Marketing and Mass Media: A Review of Trends and Practices", can be found at: http://www.pathfind.org/pf/pubs/focus/RPPS-Papers/Social%20Marketing.html

Arte y Parte

In Paraguay, a Social Marketing intervention began in June 1997 when *"Con S de Sexo"* radio show first went on the air. It was part of a comprehensive adolescent reproductive health communications project called, *Arte y Parte,* which translated means "it has everything to do with me". It kept its goals simple: (1) To increase knowledge of sexual and reproductive health among adolescents in order to promote responsible sexual behaviour; and (2) To improve communication and negotiation skills among adolescents related to sexual and reproductive health issues. To accomplish these two goals, its three principal strategies were:

- The use of peer educators;
- Adolescent-specific media product development and placement; and
- Promotion of increased media attention to adolescent reproductive health issues.

In 1998, *Arte y Parte* was honored at a TV awards ceremony with an award for educating youth, and in 1999, an evaluation showed that its message had reached 44% of the target population. Another study showed that use of modern contraception had increased, as had condom use.

Lessons Learned from *Arte y Parte* (Population Services International, 2002):

- Mass media interventions can effectively reach large numbers of adolescents at modest cost.
- As in most communications interventions, market segmentation and message targeting are crucial in interventions aimed at adolescents, as adolescents are not a homogenous group.
- While radio programming and street theatre presentations were successful in reaching Paraguayan youth, they may not be the most effective way of providing in-depth information.

- More continuous and intense interventions may be necessary in the future in order to promote amore significant behaviour changes.
- In conjunction with mass media interventions, it is also important to ensure that resources (e.g., counselors, youth centres, hotlines, and youth-friendly reproductive health services) are available to provide help to youth.
- No evidence was found supporting the belief that discussion of sexual and reproductive health issues will act as an invitation to be promiscuous and have sexual relations.

15. *Life Skills approach can effectively use peer educators*

Life skills are behaviours that enable individuals to adapt to and deal effectively with the demands and challenges of life. Such skills include (Moya, p. 1):

- Decision-making, problem-solving, critical thinking, and creativity
- The ability to analyse and clarify values
- The ability to communicate, build empathy, be assertive and to negotiate
- The ability to cope with emotions and handle stress
- Self-awareness and the ability to feel empathy with others

The life skills education approach is an "interactive, educational methodology that not only focuses on transmitting knowledge but also aims at shaping attitudes and developing interpersonal skills. The main goal of the life skills approach is to enhance young people's ability to take responsibility for making healthier choices, resisting negative pressures, and avoiding risk behaviours. Teaching methods are youth-centered, gender-sensitive, interactive, and participatory. The most common teaching methods include working in groups, brainstorming, role-playing, story telling, debating, and participating in discussions and audiovisual activities" (Moya, p. 1).

While the life skills strategies identified in a review by UNICEF do not specifically indicate the use of peer educators, it does encourage participants to "learn from each other – peer to peer – as well as from educators, family, and community, thus integrating the knowledge and experience of everyone involved" (Moya, p. 3). Furthermore, other life skills interventions do employ peer educators as part of their delivery strategy.

CHAPTER FIVE

This chapter will present a series of guidelines to address different aspects of adolescent reproductive health intervention planning and implementation. This will include overall guidelines for youth projects in general, planning for peer education efforts, implementing peer education programmes, and for the selecting and training of peer educators. There are concluding sections on Tips for an HIV/AIDS Programme, Tips for Working with Youth, Tips for Working with Adults, and, finally, a sample lesson plan from a peer educator's training manual. An examination of these guidelines will reveal a close correlation with many of the lessons learned in the previous chapter.

Overall Guidelines for Youth Programmes

- *Reproductive Health Outlook* published the following set of guidelines for successful adolescent reproductive health programmes based on lessons learned in the field. These guidelines provide the context for undertaking peer

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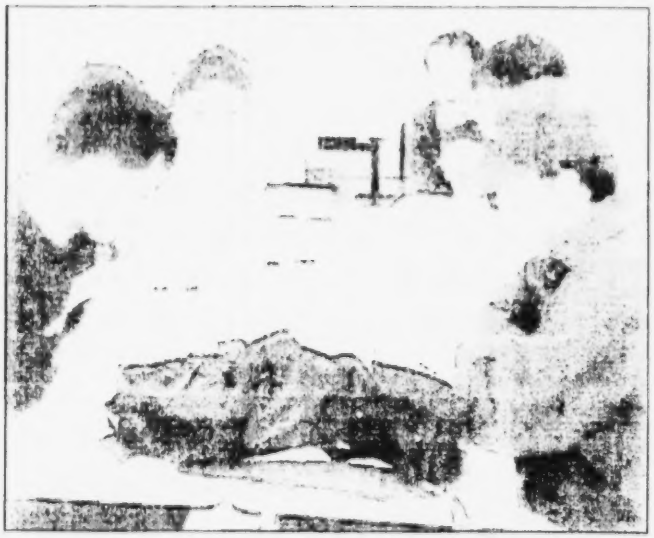
education strategies (Reproductive Health Outlook, n.d., available at: http://rho.org/html/adol_overview.htm)

- Key strategies for reaching and serving youth include:
  1. Developing youth-friendly services;
  2. Involving youth in programme design, implementation, and evaluation;
  3. Training providers to attend to the special needs and concerns of adolescents;
  4. Encouraging community advocacy efforts to support youth development and promote positive adolescent health behaviours;
  5. Implementing programmes that provide complete and accurate sexual health information;
  6. Incorporating skills-building exercises into youth programmes to help young people improve their self-esteem, develop their communication skills about sexuality, and strengthen their ability to negotiate safer sexual practices.

- Adolescent programmes work best when they provide life skills education, in addition to sexual health information and services. Programmes should help young people develop skills and talents that offer them opportunities for economic viability and develop their sense of having a potentially successful adulthood. Such opportunities, combined with reproductive health information and services, can help motivate youth to postpone sexual activity by helping them understand the long-range impact of their decisions and the importance of planning their futures.



- Both young men and women may need reproductive health education, including information on sexuality, contraception, reproduction, abstinence, abortion, STDs, and gender roles.

- Adolescent sexuality is a sensitive subject in all cultures. Programmes that offer reproductive

health services to adolescents can expect to encounter some resistance from their community.

Peer education can be an important component of many different kinds of youth intervention programmes. Guidelines in planning, implementing, training and research are offered below.

Planning a Peer Education Programme

- Begin with a clearly defined target population. Consider age, gender, race/ethnicity, sexual orientation, socio-economic factors, neighbourhoods, whether the youth are in or out-of-school, etc. If data is available from local health departments, consider which groups of youth appear to have the highest rates of STDs or unintended pregnancy when targeting the intervention. Research other existing programmes, and look for underserved members of the community.

- Include members of the defined population from the beginning of the planning process. This means you. Their participation will ensure that the programme is a product of the community, helping create a feeling of ownership in the programme and its goals rather than that it has been foisted upon the community by 'outsiders'. Youth must be invited not merely as tokens, but as full participants. Young people should be present from the beginning, and their opinions and suggestions considered seriously. Meetings should be after school, accessible by public transportation or with transportation provided. Snacks and, perhaps, child care can also help to keep young representatives participating.

- Set a clearly defined programme with realistic goals and objectives. One programme cannot address all the issues facing teens, and a group of ten teenagers will not be able to reduce rates of STDs or pregnancy in a state, county, or town in six months. However, ten teenagers could present 12 workshops to 200 students over a period of 9 months and host a health fair that reaches 350 students or, over the period of 6 months, implement a curriculum in 10 health classes at the local high school, reaching 70 students. A time period and the number of people to be reached for each objective will help define the programme and target population, and ensure measurable goals and objectives.

- Plan realistically for evaluation in the time line and budget. Whether a detailed process evaluation or a long-term impact evaluation, it must be planned from the beginning, or data gathered will be partial and inconclusive. The quantifiable objectives developed for the programme will define the data to be gathered. Changes in knowledge will be measured by pre- and post-testing peer educators and participants. Process evaluation data may include numbers and characteristics of programme activity participants, post-workshop satisfaction measures, focus groups data from workshop participants, and peer educator journal entries recording activities and referrals. Evaluation is a worthy investment. Demonstrating success encourages funders (sic) to support the programme. Process evaluation allows ongoing assessment of programme strengths and weaknesses.

- Find the right person or people to co-ordinate the programme. Much of the success of a peer education programme will rest on the programme co-ordinator(s) who must understand youth and enjoy working with them. The co-ordinator should display a non-judgmental perspective while establishing high standards of expectation for programme participants.

Implementing the Programme (Norman, 1998, pp. 1-3)

- Recruit peer educators from a broad base of potential candidates. Consider opinion leaders within the defined population, but look also for those who strongly believe in the programme's goals and objectives and want to help achieve them. Some of the most effective peer educators do not initially appear to be ideal candidates. Successful recruiters will search out young people, rather than simply expecting them to respond to a flyer or notice. Enlist teachers and other community and agency staff to make recommendations and to publicise the programme among their youth.

- Decide what incentives the programme will provide for the peer educators. Some programmes offer school credit or volunteer service hours. Local merchants may be willing to donate shirts,

snacks, or discount coupons. Other programmes build peer educator wages into their budgets. Programmes that do not pay the peer educators may attract a limited or non-representative group of candidates.

- Provide sufficient training for the peer educators. Skills development is as crucial as knowledge. Training empowers peer educators to recognise when to refer a peer to a professional person. The training should model the supportive and interactive techniques that peer educators themselves will use. Successful programmes will have ongoing training for the peer educators, times to practise existing skills and to develop new ones.

- Select a curriculum to maximise interactive and experiential learning. Peer education works best when young people work with one another to learn new things or to develop new skills. Youth lectures are no more effective than adult lectures. Peer educators should be trained in facilitating and processing as well as in giving clear directions. Peer educators gain ownership of the programme when they play a role in deciding which activities to use or in designing new ways to present the information.

- Remember that research shows peer education to be most effective when part of a comprehensive initiative. Link peer educators with school nurses, 'youth friendly' local clinics, community agencies, and programmes with similar goals. Ensure that peer educators know when and where to refer another young person. A local health professional from a teen clinic or other 'youth friendly' health provider may serve as an advisor to the peer educators and programme staff and as a link to health services.

- Monitor the peer educator's work. After the initial training, peer educators will need ongoing supervision of their work and training. Peer educators should keep a log of informal activities. Monitoring will highlight skills or knowledge that need strengthening. Feedback

will also help the young people become more skillful and effective educators.

- Provide ongoing encouragement and support. Peer educators work hard and their work is not always easy. Positive feedback and support will help keep trained youth involved, as will encouraging them to support each other and providing occasional incentives, such as pizza parties or small trips.

- Expect attrition and have a formal structure for recruiting and training new peer educators. Youth have many competing interests; some may decide they do not enjoy being peer educators. Exit interviews will help gauge whether they are leaving for personal or programmatic reasons. Involving current peer educators in the recruitment and training of new peer educators will also empower them and help them develop new skills.

- Provide opportunities for peer educators to give feedback about the programme, its activities, and their own performance. The peer educators usually know what they need to become more effective and to enjoy their work more.

- Finally, promote the programme. Develop literature showcasing services and highlighting accomplishments. Positive stories from the peer educators and feedback from workshop participants will enliven data based reports. These materials will increase visibility and encourage potential donors to invest in the peer education programme.

Selecting Peer Educators

The criteria used in selecting peer educators vary widely from project to project. Of course, characteristics that place the peer educator as a member of the target group are always taken into account. These characteristics might include age, level of education, gender, ethnicity, religion, academic interests and extra-curricular activities. Many programmes develop a list of characteristics that are designed to fit their particular needs. The

following is a list of characteristics considered generally desirable in a peer educator that have been compiled from a broad range of projects (Pathfinder, December 1997):

- A demonstrated interest in working with peers and in the community.
- The ability to be respectful, non-judgmental, and to maintain client confidentiality.
- Acceptability to the young people who they will serve.
- The ability to establish good relations with both individuals and the group as a whole.
- The ability to serve as a role model and to exercise leadership.
- The ability to deal with relevant information and programme content.
- A commitment to family planning and to positive reproductive health practices.

Training Peer Educators (Population Council, June 2000, p. 14)

- Peer educators should be involved in the design or adaptation of training curriculum and support materials. This helps to ensure the relevance of the training and ownership of the programme.
- In addition to HIV/AIDS transmission and prevention, peer education training should address sexuality and gender, interpersonal and group communication skills, and legal and ethical issues.
- Peer education training, as well as support and supervision, should be ongoing. The aim should be to increase knowledge and skills over time.
- Training should be competency-based and include initial and ongoing evaluation of competencies.
- Training should take into account the personal development of the peer educator.
- Supervision of peer educators' performance should include both field and office-based supervisory sessions.
- Programme staff supervising peer educators must be technically competent, as well as motivational and supportive.

How to Plan and Implement a Peer Education Programme for Sex Workers

The following are guidelines for the selection of peer educators, and their roles, for an intervention targeted specifically at female sex workers in Viet Nam. These guidelines are included here as an example of how to narrowly focus a peer education programme at an intended target audience.

The peer educators identified and selected in this programme were not always youth, but many, if not most of them, were.

Selection Criteria for Peer Educators:

- Should be sex workers or former sex workers,
- Must be willing to be a peer educator;
- Should be enthusiastic and has a good reputation among her peer group, is accepted and respected by the target group;
- Should be the same or similar age as the women she will be working with;
- Must have time and energy to devote to this work;
- Should have enough education to implement the activities of a peer educator. It is a priority that peer educators have an upper secondary education;
- Should have good listening skills, ability to form relationships and encourage others to learn about STDs/HIV/AIDS and change behaviours;
- Should be enthusiastic and self-confident enough to attend social activities in the community. Exhibit leadership potential; and
- Should have few personal difficulties in their own lives.

Role of the Peer Educators Selected by the above criteria (National Committee for AIDS Prevention and for Drug and Prostitution Control, n.d.., pp. 12-13) is:

- to provide information on STDs/HIV/AIDS to sex workers;
- to provide condoms and IEC materials to sex workers;
- to educate and encourage sex workers to change behaviours, such as, the 100% use of condoms in sexual relations, and clinic attendance for regular STI check-ups;
- to support members of target population when they experience difficulties, such as, suspected HIV infection or complications after having had an abortion;
- to meet once a week (or more) with the Commune Supervisor to report on their activities;
- to mobilise other sex workers to attend the programme, if necessary; and
- to follow all regulations of the programme.

Tips for HIV/AIDS Prevention Programmes

From UNICEF, the following are important tips for building a successful peer education component into an HIV prevention programme (UNICEF, n.d., pp. 2-3 of 4):

- Link the peer education programme (content and methods) with other programmes to form a comprehensive strategy
- Ensure that a quality control process is in place
- Ensure that a trained adult or teacher facilitates and supports the peer educators
- Evaluate the results of using peer educators, including:

    1. Monitoring the activities of the peers (process evaluation), for example, have progress reports submitted by the peer educators on number of people expected compared to reached, who they were and what was discussed, outcome and satisfaction surveys; as well as
    2. Measuring the impact of the education (outcome evaluation), for example: looking at HIV-related knowledge, attitudes, skills and behaviours, and/or health outcomes such as STI incidence.

- Consider incentives for peer educators to attract and maintain their participation. For example, recognise their contribution through: public recognition; certificates; programme T-shirts; food; money/ credit stipends; and scholarships.
- Establish criteria for the skills and qualities that peer educators should have and then have students volunteer or nominate others for the peer educators
- Have clear and achievable expectations for the peer educators
- Provide thorough training and regular follow-up workshops and practice sessions (this is particularly important as turnover of peer educators can be high)
- Be flexible when scheduling training and feedback sessions to maximise participation.
- Monitor the needs of the trainers and educators.
- Involve young people as active participants in the project planning, implementation and assessment. Planning processes, such as developing and pre-testing the materials, curricula or training manual, can serve as valuable opportunities for young people to practice

facilitation skills and to gain HIV prevention knowledge, while ensuring that you are reflecting the audience's cultural background and educational level.

- Make sure ample supply of educational materials and condoms are available.
- Consider the different needs of male and female educators. For example, there may be different social expectations about how girls should behave and what they should talk about in public. Also, some girls may stop serving as educators after they get married. Try to support their involvement and aim to keep a gender balance among the educators. One study found that young women were more able to "express an opinion and ask questions in girls-only HIV/AIDS peer education groups, as compared with mixed-gender groups"
- Prepare the peer educators for community resistance and public criticism, should it arise. At the same time, inform and involve the community in the programme, to alleviate any fears and to garner their support. (e.g. the mothers and fathers of the peer educators, grandparents, aunts and uncles, religious leaders, community advisory committees, etc.)
- Ensure that mechanisms are in place to replenish the supply of peer educators. (who will get older and mature out of the programme)

Tips for Working with Youth

These tips were developed by Advocates for Youth's Teen Council with assistance from the Young Women's Project, Washington, DC (Advocates for Youth, *Transitions, October 2001*, p. 15):

- Be open to and non-judgemental about young people's insights and suggestions. Let them know that their involvement is important.
- Take advantage of the expertise that teens offer. Young people know about, and should be encouraged to share, the needs of their community. Affirm this input.
- Make sure youth will participate in meaningful ways. Young people should be involved in making decisions from the beginning of the project. Actively seek teens' opinions.
- Be honest about expectations for the project, what you want the teens to contribute, and how you hope to benefit from teen

participation. Don't expect more from a teen than you would from an adult. Keep expectations realistic; hold young people to your expectations. Do not patronize youth by lowering expectations.

- Integrate young people into group and coalition efforts. Schedule meetings when teens can attend and in a location accessible to them. Like everyone else, keep young people informed about plans and meeting times.

- Treat teens as individuals. Don't assume one teen represents the views of many teens. Assure the young person that you are interested in her/his individual opinion and don't expect him/her to speak for an entire population.

- Be prepared ahead of time to offer support. Think about kinds of support (financial, logistical, training, emotional, etc.) it will take to involve teens in the project, and who will be responsible for providing this support.

- Make the work interactive, fun, and valuable. Like adults, youth are more likely to get involved and remain active in projects that are interesting and fulfilling.

- Many youth feel intimidated by adults and are not used to participating in discussions with adults. Some may feel they have nothing to contribute. It will require time and commitment to get the input of these youth. Be aware of this factor and work to overcome it.

- Don't make assumptions about what individual young people are like.

- Don't move too fast. Remember that it takes time to develop trust and rapport with youth because some youth are unsure about adults' intentions. Take the time and make the effort to develop a good relationship with youth *before* expecting much. Remember, too, that this work is often new to youth; take the time to explain why actions are being taken. Youth may interpret adults' being abrupt and hurried as a sign of disinterest in youth's participation; so go slow and explain what's going on.

- Remember that there are times when youth need to say, "No." They have many competing interests and responsibilities in their lives. Their education is important. Their relationships and communities are important. Having fun is important. They need time and energy for these interests and responsibilities.

Tips for Working with Adults

These tips were developed by Advocates for Youth's Teen Council with assistance from the Young Women's Project, Washington, DC (Advocates for Youth, *Transitions, October 2001,* p. 16):

- Most adults have good intentions. Remember that they are simply not used to working in partnership with young people.

- Criticism doesn't necessarily mean condescension or that an adult doesn't value your contribution. It may mean the adult is treating you the same way he/she would an adult colleague. Remember that adults are used to critiquing each other's work and offering constructive ideas to improve a project. Just because an adult doesn't agree with someone, it doesn't mean that he/she disrespects that person.

- Adults may not be aware of the capabilities of young people. They can be told a hundred times that young people are mature, but showing them is the best way to make the case.

- Adults often feel responsible for the success or failure of the project. This is what makes it hard for them to share power. They may need reassurance that you are willing to share in both the successes and the failures.

- Adults are just as uncertain as youth. They have just learned to disguise it better.

- Sometimes adults use phrases and expressions, whether consciously or not, that annoy young people and are red flags that they aren't treating youth as partners. These phrases and expressions can erode a relationship. Be prepared to call adults on their language.

- Don't be afraid to ask for clarification. Adults often use words, phrases, and acronyms that you might not understand. Adults new to the programme may also not understand them either. The language of the non-profit sector is riddled with terms that may bewilder any newcomer.

- Don't be afraid to say, "No." Adults will understand that you have other important commitments, like your education, family, friends, hobbies, and sports.

A Sample Lesson Plan from a Peer Educator's Training Manual

This is a sample lesson plan taken from a training manual, "How to Guide Reproductive Health in Refugee Situations". It is easily adaptable and offers insight as to how to develop training materials.

PEER EDUCATION

OBJECTIVES:

- Define what a peer educator is.
- List the qualifications of a peer educator.
- Know the responsibilities of an IRC peer educator.
- Understand the importance of peer educators serving as role models of safe behaviour.

PROCEDURE:

1. **Define peer educator.**

   Ask participants to give their own definitions of peer educator. Post the definition listed below and have a participant read it aloud.

   A *peer educator* is a person who is trained to educate other people around his or her own age about a specific topic.

   Explain that they are here to become peer educators who will educate other students about using condoms to prevent unwanted pregnancy, STDs and AIDS.

2. **Discuss the qualifications of a peer educator.**

Ask participants to brainstorm a list of the qualifications they think are needed by peer educators. Record the list on the board or a piece of chart paper. When there are no other ideas from participants, post the list of qualifications written below and compare the two lists. Discuss the differences. Decide whether participants would like to add any of our ideas to their list.

Qualifications of a peer educator:

- Active and lively
- Easy-going
- Accepted and respected by peers
- Able to lead by example/be a role model
- Willing to listen to other people's views
- Comfortable talking about sexuality and condom use
- Able to organize personal schedule to permit accomplishment of peer education responsibilities.

3. **Discuss the responsibilities of an IRC peer educator.**

Ask participants to brainstorm a list of possible tasks and responsibilities of IRC peer educators. Record the list on the board or a piece of chart paper. Post the list of responsibilities written below and compare the two lists. Make sure to discuss any responsibilities on our list that were not identified by participants. Discuss whether these are responsibilities participants feel they can undertake.

Responsibilities of an IRC peer educator:

- Educate your peers about human reproduction and the prevention of unwanted pregnancy.
- Educate your peers about the transmission and prevention of STDs and AIDS.
- Promote the use of condoms among IRC students and teachers in order to prevent unwanted pregnancy, STDs, and AIDS.
- Sell condoms to IRC students and teachers.
- Keep a log of the condoms you sell and turn the log in every month.
- Serve as a role model for condom use and STD/AIDS prevention.

- Respect the people who come to talk to you or to buy condoms from you.
- Be willing to listen carefully.
- Make the person feel comfortable enough to talk to you
- If the person has a problem, help him or her come up with his or her own solutions.
- Answer the person's questions if you are able.
- If you do not know the answers, refer the person to someone who can answer the question.
- If a person comes to you with a health problem, refer him or her to the nearest clinic.
- Make sure you keep the things people tell you private.
- Turn in a report of your activities every month.

4. **Understand the importance of serving as a role model of safe sexual behaviour.**

Ask participants to define the words role model. Then, post the definition below.

A *role model* is a person whose behaviour guides other people. There behaviour shows what other people consider to be good.

Ask participants to name people they consider to be role models. Write these names on the board. Ask them what it is about these people that makes others look up to them.

5. **Role plays about role models**

Select four participants to take part in the role plays. Hand each pair of participants a card describing their roles. Give each group about five minutes for their skit.

Role Play #1: Bob is an IRC peer educator. He always has three or four different girlfriends and he likes to brag about his sexual ability. He has planned two or three condom promotion activities, but very few people have attended. He is talking to his friend Peter about what has gone wrong.

Role Play #2: Beatrice is an IRC peer educator. She is number one in her class and is the president of her school's health club. She has had

the same boyfriend for the past two years. She and her friend Mabel are talking about why Beatrice has had more people attend her condom promotion activities than Bob even though he has more friends.

Discuss the role plays.

What are the differences between Bob and Beatrice? Which one is a good role model? What makes her a good role model? Why isn't Bob a good role model? How has this affected his work as a peer educator?

Ask participants what they think is the key to being a good role model as an IRC peer educator. Try to get them to come up with something like "Make your actions fit your words".

(Flax, Valerie; James-Traore, Tijuana A., comps (1998), *Reproductive health education for adolescents*. N'zerekore: UNHCR. 88 p. [How to guide reproductive health in refugee situations, no. 3]).

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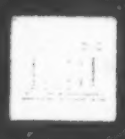

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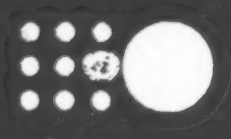

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